Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 26, 2015	2015_191107_0011	H-002401-15	Resident Quality Inspection

Licensee/Titulaire de permis

SPECIALTY CARE MISSISSAUGA INC.
400 Applewood Crescent Suite 110 VAUGHAN ON L4K 0C3

Long-Term Care Home/Foyer de soins de longue durée

SPECIALTY CARE MISSISSAUGA ROAD
4350 MISSISSAUGA ROAD MISSISSAUGA ON L5M 7C8

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

MICHELLE WARRENER (107), CATHIE ROBITAILLE (536), DARIA TRZOS (561)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): May 28, 29, June 2, 3, 4, 8, 9, 10, 11, 12, 2015

The following inspections were completed concurrently with this Resident Quality Inspection:
CIS #2956-000029-14, H-001506-14
CIS #2956-000002-15, H-002037-15 - closed with inquiry
CIS #2956-000004-15, H-002119-15

During the course of the inspection, the inspector(s) spoke with Residents, family members of residents, President and Chairs of the Resident and Family Councils, the Executive Director, Director of Care, both Assistant Directors of Care, Registered Nurses (RNs), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Director of Resident and Family Services, Director of Dietary, Food Services Supervisor, Dietary Aides, Temporary Registered Dietitian, Office Manager, Environmental Services Manager, Laundry and Maintenance staff

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **14 WN(s)**
- **9 VPC(s)**
- **3 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that action was taken and outcomes evaluated when resident #011 experienced significant weight changes and weight change that compromised the resident's health status.

Resident #011 was assessed by the Registered Dietitian with strategies implemented to address poor nutritional intake and chewing difficulties. The resident's weight was within their target weight range with a goal for weight maintenance. The resident continued to lose weight in the subsequent months and the resident fell below their target weight range.

The resident was re-assessed by the Registered Dietitian at the quarterly review. The Dietitian identified the weight loss and poor intake; however, the nutritional strategies were not revised and action was not taken in response to the significant weight loss and weight loss below the resident's goal weight range. The goal at the quarterly was for weight maintenance. The Registered Dietitian confirmed that strategies were not revised after the significant weight loss was identified.

The resident continued to lose weight and had poor nutritional intake. The resident's next weight showed a triggered weight loss warning over 3 months and another significant weight loss the next month for one, three, and six months. Nutritional strategies were not revised and the Registered Dietitian was not referred until one month after the triggered significant weight loss warning. The Registered Dietitian confirmed a referral was not received for the triggered weight warning. The resident was not re-assessed by the Registered Dietitian over a two month period.

During interview with the resident's Power of Attorney (POA), the POA stated that the resident's weight loss resulted in their dentures not fitting properly (too loose), thereby further affecting the resident's nutritional intake and ability to chew.

Action was not taken to address the resident's ongoing weight loss over a four month period. Nutritional strategies were not revised despite ongoing and significant weight loss and poor nutritional intake. [s. 69.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #002's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

During interview with the inspector the resident stated they had significant pain. The resident was visibly in pain and stated they had sharp pain that was not relieved.

The Registered Nurse stated that pain related to any skin related concerns would be documented and assessed using the weekly skin assessment tool/note. One completed skin assessment identified the area was sensitive to touch, however, an assessment of the pain using a clinically appropriate assessment instrument was not completed. The RN confirmed that an assessment of the pain was not completed during that skin assessment. Pain was rated on a scale of 1-10 in the notes on two other occasions; however, an assessment of the pain using a clinically appropriate assessment instrument specifically designed for pain was not completed.

The home's policy, "Pain and Symptom - Assessment and Management Protocol VII-G-70.00", revised February 2013, directed staff to conduct and document a pain assessment when: there are behaviours exhibited by the resident that may be an indicator for the onset of pain; when there is a change in condition with pain onset; with diagnosis of a painful disease; when resident reports pain or symptoms of greater than 4/10 or 24 to 48 hours; with history of unexpressed pain; with distress related behaviours

or facial grimacing; when report from resident, family, staff/volunteers that pain is present; and directed staff to determine the type of pain utilizing Point Click Care (PCC) pain assessment.

The pain assessment tool on Point Click Care (PCC) had not been completed for almost one year.

The skin/wound assessment progress note, identified the resident was sensitive to touch and rated the pain a 7/10. A pain assessment using a clinically appropriate assessment instrument specifically designed for pain was not completed at that time and interventions related to pain were not revised.

Progress notes from the Nurse Practitioner identified the resident had more pain. A pain assessment using a clinically appropriate assessment instrument specifically designed for pain was not completed at that time.

Weekly pain assessment notes discussed other areas that the resident had pain; however, did not include the area the resident stated was painful.

A clinically appropriate pain assessment was not completed when the resident sustained the injury, when there were voiced complaints of pain by the resident, and documentation reflected an increase in pain. [s. 52. (2)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).**

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

A) Minimum Data Set (MDS) quarterly assessments were reviewed for resident #011 over a six month period. According to the MDS assessments resident #011 had a decline in bladder continence from being usually continent of bladder to occasionally incontinent of bladder. The resident also had a decline in bowel continence, from being continent of bowel to frequently incontinent of bowel. The registered staff indicated that the resident had a decline in bowel and bladder continence and confirmed that when there was a significant change in continence a "Bladder and Bowel Continence Assessment" was required to be completed. The ADOC confirmed that a new assessment tool was developed after the last Resident Quality Inspection (RQI) in October 2014 and staff were advised to complete the assessment using the "Bladder and Bowel Continence

assessment" in Point Click Care (PCC). Prior to that, the home had a paper copy of the assessment tool. The resident's health records were reviewed and the assessment of bladder and bowel continence could not be found for resident #011 when there was a decline. The ADOC confirmed that the bladder and bowel continence assessment was not completed for the resident when there was a significant change in continence. (561)

B) The licensee has failed to ensure that resident #008, who had a change in their level of bowel continence, received an assessment that was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

The resident had a decline in their bowel continence from usually continent of bowels to occasionally incontinent of bowels identified at the quarterly review (identified in the RAI-MDS coding and interdisciplinary care conference summary).

Registered staff stated that they were required to complete a continence assessment on PCC if there was a change in the resident's level of continence. The ADOC and registered staff confirmed a continence assessment using a clinically appropriate assessment instrument was not completed when there was a change in the resident's level of continence. (107)

C) The licensee has failed to ensure that resident #016 received an assessment using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence when the resident had a change in their level of bowel incontinence.

Resident #016 had an assessment related to continence when the resident was admitted to the home. The assessment stated the resident was continent of bowels at that time (seven day observation period was consistent with the resident being continent of bowels). According to PSW flow sheets and PSW/registered staffing interview, the resident became frequently incontinent of bowels.

Flow sheets over a month and a half reflected the resident had 27 incidents of bowel incontinence. Interview with the PSW who routinely provided care for the resident identified that the resident was incontinent almost daily and the current interventions were not effective to manage the resident's incidents of incontinence.

An assessment of the resident's continence was not completed using a clinically

appropriate assessment instrument that was specifically designed for assessment of incontinence when the resident's continence level changed and the current interventions were unsuccessful. Staff confirmed that a continence assessment using a clinically appropriate assessment instrument was not completed since the admission continence assessment. (107) [s. 51. (2) (a)]

2. The licensee has failed to ensure that resident #016 was provided with a range of continence care products based on their individual assessed needs.

Resident #016 was independent with ambulation. Documentation reflected the family of resident #016 were paying for incontinence products for the resident. The POA for resident #016 confirmed to the inspector that only one type of incontinence product was offered by the home and they were unaware that the home would be able to provide a different product for the resident. The POA stated that the resident did not want to wear the original product offered by the home and was refusing to wear the incontinence product. The POA was supplying incontinence products that met the needs of the resident.

The home's "Tena Incontinence Management System New Admission and Product Change Form" did not include the option of an alternative incontinence product and staff interviewed in the home stated that the home did not offer alternative products and that families would have to provide the product if it was required for a resident. The Director of Care stated that the home did offer a product; however, documentation and interview with the resident's POA did not support that the home's product had been offered to resident #016.

The home's policies, "Continence Care Products and Continence Products Management, VII-E-10.04 and VII-E-10.09", revised November 2013, stated, "In the event a resident wishes to purchase her or his own continence care products, document the reasons for doing so on the residents care plan. Reasons will include an explanation as to why the resident, SDM or family member deems the products offered by the home to be inadequate in meeting the resident's needs. Documentation for resident #016 did not include this information and the family stated alternative options had not been offered by the home. [s. 51. (2) (h)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that residents are provided with a range of incontinence products that are based on their individual assessed needs, properly fit the residents, promote resident comfort, ease of use, dignity and good skin integrity, promote continued independence wherever possible, and are appropriate for the time of day, and for the individual resident's type of incontinence (r. 51(2)(h)), to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home was a safe and secure environment for its residents the evening of June 9, 2015.

Resident #046 was observed sitting in a wheelchair pushed up to the table in a resident lounge. The resident was sitting in-front of a tray of beverages and different types of cookies on it; the resident was eating the cookies from the tray. Staff were not present in the lounge and the call bell was not within reach of the resident.

The resident's plan of care stated they required supervision for eating. The resident required a special diet in a modified texture with assistive devices for eating.

When asked by the Long Term Care Homes (LTCH) Inspector, staff stated that the food was left from another resident at the afternoon snack pass and it was left in the lounge area. Resident #046 required staff assistance for ambulation in their wheelchair and staff were not sure why the resident was positioned and left unattended at the table with the tray of food in-front of the resident. [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The plan of care for residents did not provide clear direction to staff and others who provided direct care to the residents.

A) On June 10, 2015, the LTC Inspector reviewed the plan of care for resident #026, who had multiple responsive behaviours identified. The current plan of care, which the home referred to as the care plan, identified new interventions for dental care. On June 12, 2015, the kardex, which the Personal Support Worker (PSW) identified as the plan of care they used for provision of care for resident #026, did not identify the new dental care interventions. The PSW staff and the Registered Practical Nurse (RPN) confirmed that the plan of care did not provide clear direction to staff who provided care for resident #026. (536)

B) Resident #038 reported that an identified PSW caused pain while assisting with care and then did not place a call bell within their reach. During interview with the LTCH inspector, the PSW stated that she was new to the unit and was not aware of resident being prone to pain and was not aware that the resident had a preference for the placement of the call bell in a certain spot. The written plan of care and Kardex did not indicate the placement of the call bell in a certain spot for easier reach. The kardex did not indicate that the resident had pain and did not provide specific direction to staff about handling of the resident during care to minimize pain. The interview with the ADOC who conducted the investigation after the incident occurred indicated that the home could not confirm that rough handling occurred. The ADOC did confirm that the written plan of care and Kardex did not provide clear direction to staff with specific interventions that were in place for the resident. This caused the resident to be upset. The home failed to ensure that the plan of care provided clear direction to staff. (561) [s. 6. (1) (c)]

2. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

A) Resident #038 sustained an unwitnessed fall with no injury. The resident was not considered a falls risk prior to the incident. The home's expectation was to conduct a post fall assessment and a post fall huddle with an interdisciplinary team after the fall. According to the ADOC the post fall huddle was completed to review the current interventions and to discuss any strategies that needed to be implemented to prevent future falls based on the individual needs of the resident.

The health care records indicated that the post fall assessment was done by registered staff, but the post fall huddle was not completed with an interdisciplinary team after the fall occurred. The registered staff that completed the post fall assessment updated the written plan of care with new interventions. Interview with a PSW that provided direct care to the resident indicated that the resident did not require the interventions that were added to their plan of care. The resident only required one of the interventions added to the plan of care.

Interview with the ADOC confirmed that the post fall huddle was not completed after the fall occurred and the registered staff added the interventions to the written plan of care without consulting the interdisciplinary team. The ADOC indicated that the resident did not require any interventions in place at this time except for one. The home did not ensure that staff collaborated with each other in the assessment of the resident post fall. (561)

B) The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of resident #008 so that their assessments were integrated, consistent with and complemented each other.

The coding on the Resident Assessment Instrument - Minimum Data Set(RAI-MDS) assessment completed for the quarterly review identified the resident was occasionally incontinent of bowels and frequently incontinent of bladder. The interdisciplinary care conference narrative for continence at the quarterly review identified the resident was continent of bowels and occasionally incontinent of bladder. The care summary for the interdisciplinary conference identified the resident was frequently incontinent of bladder and noted a worsening of bowel continence. Different staff completed the different assessments. Information related to the assessment of the resident's continence was not consistent across the different assessments. The Director of Care confirmed the information was not consistent across the different documents. (107)

C) The licensee has failed to ensure that information between assessments was consistent in relation to resident #022's required fluid consistency.

The assessment completed by the Registered Dietitian identified the resident required a certain consistency thickened fluids; however, the resident's plan of care, physician's orders, and dining serving lists identified a different consistency of thickened fluids. It was unclear from the Dietitian notes if the resident was meant to be switched to a

different consistency of thickened fluids or if it was an error. The Registered Dietitian was not available for clarification and registered nursing staff were unclear why the assessments were not consistent. (107) [s. 6. (4) (a)]

3. The licensee failed to ensure that the care set out in the plan of care was provided to resident #043 as specified in the plan.

The written plan of care for resident #043 stated that staff were to make sure the resident had a way of calling for staff assistance with care. The resident and PSW confirmed the resident preferred the bell to be in a certain location for accessibility.

The resident alleged that their call bell was placed out of reach during the night shift. The resident had mobility limitations. Investigation notes by the home identified that the resident's call bell was located in a different location when the staff came on duty the next shift. Staff confirmed the call bell was not within the resident's reach that shift and the resident did not have a way to call for staff assistance without the call bell being within reach.

Discipline was provided to the staff in relation to not following the resident's plan of care that required the resident to have a way to contact staff for assistance when needed. [s. 6. (7)]

4. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A) Resident #011's RAI-MDS quarterly assessments indicated that they had a decline in bladder continence from being usually continent of bladder to occasionally incontinent of bladder. The resident also had a decline in bowel continence, from being continent of bowel to frequently incontinent of bowel.

Review of the resident's health records indicated that the resident was not assessed when there was a change in resident's continence.

The written plan of care was not revised at the time of the change and indicated that the resident was still continent of bladder and bowel.

The registered staff member was interviewed on June 10, 2015 and indicated that the

resident had recent changes in continence and their brief type was changed. The written plan of care did not indicate what type of incontinent product the resident was using.

The plan of care was not reviewed and revised when the resident had a change in bowel and bladder continence. (561)

B) The licensee has failed to ensure that resident #016 had their plan of care revised when the resident's care needs changed in relation to bowel continence.

The resident had a decline in their level of bowel continence after admission and was frequently incontinent of bowels. The resident had 31 documented incidents of bowel incontinence over a one and a half month period. Staff confirmed the resident's written plan of care was not revised to reflect the change in continence and the interventions/strategies the home was using to address the incidents of incontinence after the resident's bowel incontinence worsened. The written plan of care identified the resident remained usually continent of bowels and that the resident was to wear a certain incontinence product. PSW staff that frequently cared for the resident stated that the resident was frequently incontinent, refused to wear the incontinence product identified on the plan of care, resulting in multiple episodes of incontinence.

The resident's plan of care was not revised in relation to the increasing episodes of bowel incontinence. (107)

C) The licensee has failed to ensure that the written plan of care for resident #044 was revised when the resident's care needs changed. The resident's condition significantly deteriorated and the resident was identified as palliative, requiring end of life care . The resident's plan of care was not revised to reflect the change in condition and the planned care for the resident in relation to the palliative care measures. The written plan of care still required the resident to be up daily and the goals identified on the plan did not reflect the resident's deteriorated condition. Staff confirmed the resident's written plan of care was not revised to include end of life care for the resident when the resident's condition deteriorated. The home's policy, "Palliative Care - Care of the Resident VII-G-30.30", stated that, "All palliative residents should have comprehensive assessments and a current, up to date plan of care which will be completed using an interdisciplinary approach." (107) [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with s. 6(1)(c), s. 6(4)(a), s. 6(7), s. 6(10)(b), to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the home's Missing Resident Laundry policy was complied with.

The home's policy "Missing Resident Laundry -policy # XII-K-20.50", past revision April 2011, current revision January 2015, stated that "all missing personal clothing that is reported will be recorded on the Missing Laundry Form and every effort will be made to locate it". The LTC Inspector spoke with both the Laundry Aide and Personal Support Workers(PSW's), who confirmed they do not complete the Missing Laundry form. The registered staff interviewed stated that they either communicated to the Laundry Services Manager by email, or by telephone. Interviews with the Laundry Services Manager identified that the home was trying to reduce their carbon footprint and that the Missing Laundry form was not currently in use. He also confirmed that telephone messages, emails, and an online tracking tool were used for this process. An interview with the Administrator confirmed that the home was now using an online tracking tool to track missing clothing, and the Missing Laundry Form was not currently in use. This non-compliance was also issued as a VPC at the 2014 RQI. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, (b)is complied with, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails were used, (a) the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

A) The home was unable to provide evidence that all beds in the home had been assessed and evaluated in relation to entrapment hazards and risk to residents. The document provided to the LTCH inspector on June 11, 2015, included 30 bed entrapment hazard assessments; however, the home was unable to locate evidence that the additional 130 beds in the home had been evaluated for safety since 2010.

Interview with the Maintenance Manager confirmed that due to staffing turnover, the documents were unable to be located.

B) The licensee has failed to ensure that when bed rails were used, the resident was assessed in accordance with evidence-based practices and if there are none, in accordance with prevailing practices to minimize risk to the resident.

Resident #008 had a plan of care that included a rail on one side of the bed to assist with bed mobility and a different rail on the other side of the bed to assist with transferring. Registered staff looked for an assessment of the resident in relation to the bed rails, however, were unable to find one. Staff confirmed that an assessment of resident #008 was not completed in relation to bed rail safety. [s. 15. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that where bed rails are used, (a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

The licensee has failed to ensure that an interdisciplinary assessment related to pain was completed after resident #002 sustained an injury. Documentation reflected the presence of pain, and the resident voiced pain to the LTCH Inspector; however, the resident's written plan of care (the document the home referred to as the care plan) did not include the identified pain or strategies to manage the resident's pain. The resident also had pain in other locations for which they were receiving treatment, however the resident's written plan of care did not include the identified pain. [s. 26. (3) 10.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring a plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 10. Health conditions, including allergies, pain, risk of falls and other special needs, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee did not ensure that resident #002, who sustained a skin injury, received immediate treatment and interventions to reduce or relieve pain.

During interview, the resident stated they had significant pain related to an injury. The resident was visibly in pain and stated they had sharp pain that was not relieved.

The skin/wound assessment progress note, identified the resident was sensitive to touch and rated their pain a 7/10.

Progress notes from the Physician identified the wound was tender.

Progress notes from the Nurse Practitioner identified that staff reported the resident's wound was worse with more pain.

The skin assessment identified the area was sensitive to touch.

Interventions related to pain were not revised after the resident sustained the injury and treatment was not provided to reduce or relieve the pain. The resident received as needed pain medication on one day only.

The resident's written plan of care (the document the home referred to as the care plan) did not include pain or strategies to reduce pain. [s. 50. (2) (b) (ii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(ii) receive immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all food was prepared, stored, and served using methods which preserved taste, nutritive value, appearance and food quality.

A) Texture modified foods were not prepared in a manner that preserved nutritive value, appearance and food quality.

At the lunch meal May 28, 2015, the pureed beets and bean salad were too runny and did not hold their form on the plate. The pureed menu items were running into one another on the plate, resulting in reduced visual appeal and reduced nutritive value from the addition of too much liquid.

At the lunch meal June 3, 2015, the minced and pureed texture coleslaw, pureed beef pot pie, pureed peas, and pureed rice pudding, were too runny and items were running together on the plates.

At the lunch meal June 8, 2015, the minced and pureed roast pork, minced and pureed carrots, minced and pureed salad were too runny and the items were running into one another on the plate.

At the dinner meal June 9, 2015, the pureed fish and green beans were too runny and the items were running together on the plate.

B) Frozen desserts (ice cream, sherbet) were left sitting at room temperature for most of the meal service at the lunch meals May 28, June 8, and June 10, 2015. The dessert was almost completely melted for the last few residents receiving dessert. Some of the frozen dessert was then covered and re-frozen for residents receiving tray service. At the lunch meal June 10, 2015, the orange sherbet looked like it had previously melted a bit then was re-frozen prior to serving. The ice cream/sherbet had an altered texture and the visual appearance of the dessert was reduced.

C) The recipe for the roast pork sandwich served at the lunch meal June 8, 2015, required a 3 ounce (oz) portion of pork. The sandwich served to residents contained only one thin slice of pork (not 3 oz). The nutritive value of the meal was reduced.

The 2014 resident satisfaction survey identified resident concerns with the visual appeal of meals. During stage one of this inspection residents voiced concerns over the visual appeal of meals and the lack of filling in sandwiches. [s. 72. (3) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a)preserve taste, nutritive value, appearance and food quality, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff that provided direct care to residents were provided training related to falls prevention on either an annual basis, or based on the staff's assessed training needs.

The home's training records for 2014, related to fall prevention were reviewed. It was identified that there were 124/148 or 84 percent (%) of direct care providers trained in 2014. The attendance breakdown for training identified: 87 out of 100 PSWs (87%), 11 out of 14 RNs (79%) and 26 out of 34 RPNs (77%) attended and completed training on falls prevention in 2014. The ADOC confirmed that not all staff attended training for falls prevention. The home failed to ensure that all direct care providers were provided annual training in falls prevention. [s. 221. (1) 1.]

2. The licensee has failed to ensure that staff that provided direct care to residents were provided training related to continence care and bowel management on either an annual basis, or based on the staff's assessed training needs.

The home's training records for 2014, related to continence care and bowel management were reviewed. It was identified that there were 93/145 or 64 percent (%) of direct care providers trained in 2014. The attendance breakdown for training identified: 64 out of 100 PSWs (64%), 4 out of 13 RNs (31%) and 25 out of 32 RPNs (78%) attended and completed training on continence care and bowel management in 2014. The ADOC confirmed that not all staff attended training for continence care and bowel management. The home failed to ensure that all direct care providers were provided annual training in continence care and bowel management. [s. 221. (1) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that for the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:

1. Fall prevention and management.

3. Continence care and bowel management., to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident had the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004, kept confidential in accordance with the Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with the Act.

On May 28, 2015, during the initial tour, a LTCH Inspector observed a grey bin on the floor in an activity room; the doors to the room were wide open. The grey bin had signage indicating, "medication pouches disposal only". There was a big enough slot in the bin that a hand could easily pass through and empty medication pouches could easily be removed. The bin was full exposing the medication pouches. A few of the empty medication pouches were removed and contained residents' names on them. On July 9, 2015 the DOC confirmed that empty medication pouches could have been easily taken out of the bin and indicated that a new larger bin has been ordered. A new sign was placed on the bin not to dispose of the empty pouches until the new bin came in. The licensee did not ensure that resident's personal health information was kept confidential. [s. 3. (1) 11. iv.]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

The home's policy called "Abuse and Neglect of a Resident - Actual or Suspected", policy number VII-G-10.00 revised April 2013 indicated "All complaints (verbal or written) from residents, families, visitors and staff that concern a reportable matter as set out in section 24 of the Long Term Care Act, 2007 shall be immediately reported and investigated. Reportable matters include: any incident with respect to alleged, suspected or witnessed abuse of a resident by anyone or alleged, suspected or witnessed neglect or a resident by the home or staff..."

Resident #038 reported to registered staff that a PSW was "very rough" while providing care. The home did not immediately report the incident of alleged rough handling to the Director and the Critical Incident was not submitted to the Ministry of Health and Long Term Care. The internal investigation was completed in the home and concluded that the incident could not be verified or confirmed and therefore the incident was not reported. The ADOC who completed the investigation confirmed that the incident of alleged abuse was not reported to the Director. The home did not follow their policy on reporting of alleged abuse. [s. 20. (1)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(a) is a minimum of 21 days in duration; O. Reg. 79/10, s. 71 (1).

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee did not ensure that the home's menu cycle, (a) was a minimum of 21 days in duration.

The Director of Dietary confirmed that the home's snack menu cycle was 14 days in duration, with multiple items repeated throughout the two weeks. Sandwiches and cookies were served for the evening snack almost daily. Sandwiches were also served at the lunch meal almost daily in addition to the evening snack and cookies were offered at the afternoon snack pass almost daily. The menu cycle was not a minimum of 21 days in length to ensure adequate variety of items were being offered to residents.

The dessert menu also appeared repetitious with pudding and sherbet served five to seven times per week. Documentation in the Pleasurable Dining meeting minutes did not reflect that this was a resident preference. [s. 71. (1) (a)]

2. The licensee has failed to ensure that all planned menu items were offered at each meal.

At the observed lunch meal June 3, 2015, resident #022 was not offered the planned dessert. The resident had a history of poor intake and poor hydration and was at high nutritional risk. PSW staff assisting with the meal stated the resident was only to receive a special item for dessert and not the dessert identified on the planned menu. The special item had been ordered for the resident as a preferred item and as a measure to increase the resident's nutritional intake. The Director of Dietary and Food Services Supervisor confirmed the resident was to be offered the planned dessert in addition to the special item at meals.

At the lunch meal June 3, 2015 and the dinner meal June 9, 2015, not all residents were offered bread with their meal (as per the planned menu). Several residents requiring a minced texture or pureed texture menu did not have bread included in the meal. The PSW assisting resident #047 confirmed the resident was not provided bread at the meal and that the lack of bread was not due to resident preference. Not all planned menu items were offered to residents. [s. 71. (4)]

Issued on this 26th day of August, 2015

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MICHELLE WARRENER (107), CATHIE ROBITAILLE (536), DARIA TRZOS (561)
Inspection No. / No de l'inspection :	2015_191107_0011
Log No. / Registre no:	H-002401-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 26, 2015
Licensee / Titulaire de permis :	SPECIALTY CARE MISSISSAUGA INC. 400 Applewood Crescent, Suite 110, VAUGHAN, ON, L4K-0C3
LTC Home / Foyer de SLD :	SPECIALTY CARE MISSISSAUGA ROAD 4350 MISSISSAUGA ROAD, MISSISSAUGA, ON, L5M-7C8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Gayle Stuart

To SPECIALTY CARE MISSISSAUGA INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 69. Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Order / Ordre :

The licensee shall prepare, submit, and implement a plan that ensures that action will be taken and outcomes evaluated for significant weight changes or weight change that compromises a resident's health status. The plan shall include, but is not limited to:

1. Review of the home's policy related to weight change and education for direct care staff. Please include education related to referrals to the Registered Dietitian and the interdisciplinary role in the assessment and follow up of weight change.
2. Any quality monitoring activities the home will be using, including person responsible and frequency of auditing, as applicable.

The plan shall be submitted to Long-Term Care Homes Inspector Michelle Warrener, via email to: Michelle.Warrener@ontario.ca, by July 10, 2015.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that action was taken and outcomes evaluated when resident #011 experienced significant weight changes and weight change that compromised the resident's health status.

Resident #011 was assessed by the Registered Dietitian with strategies implemented to address poor nutritional intake and chewing difficulties. The resident's weight was within their target weight range with a goal for weight maintenance. The resident continued to lose weight in the subsequent months and the resident fell below their target weight range.

The resident was re-assessed by the Registered Dietitian at the quarterly review. The Dietitian identified the weight loss and poor intake; however, the nutritional strategies were not revised and action was not taken in response to the significant weight loss and weight loss below the resident's goal weight range. The goal at the quarterly was for weight maintenance. The Registered Dietitian confirmed that strategies were not revised after the significant weight loss was identified.

The resident continued to lose weight and had poor nutritional intake. The resident's next weight showed a triggered weight loss warning over 3 months and another significant weight loss the next month for one, three, and six months. Nutritional strategies were not revised and the Registered Dietitian was not referred until one month after the triggered significant weight loss warning. The Registered Dietitian confirmed a referral was not received for the triggered weight warning. The resident was not re-assessed by the Registered Dietitian over a two month period.

During interview with the resident's Power of Attorney (POA), the POA stated that the resident's weight loss resulted in their dentures not fitting properly (too loose), thereby further affecting the resident's nutritional intake and ability to chew.

Action was not taken to address the resident's ongoing weight loss over a four month period. Nutritional strategies were not revised despite ongoing and significant weight loss and poor nutritional intake. [s. 69.] (107)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2015

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Order / Ordre :

The licensee shall prepare, submit, and implement a plan that ensures that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. The plan shall include, but is not limited to:
1. A review of the home's pain management policy to ensure it provides clear direction for staff on the required process to follow when residents exhibit pain or have ongoing pain.
2. Education for staff related to the home's pain management program and policies.
3. Any quality management activities the home is implementing, including person responsible and frequency of auditing, as applicable.

The plan shall be submitted to Long-Term Care Homes Inspector Michelle Warrener via email to: Michelle.Warrener@ontario.ca, by July 10, 2015.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that when resident #002's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

During interview with the inspector the resident stated they had significant pain. The resident was visibly in pain and stated they had sharp pain that was not relieved.

The Registered Nurse stated that pain related to any skin related concerns would be documented and assessed using the weekly skin assessment

tool/note. One completed skin assessment identified the area was sensitive to touch, however, an assessment of the pain using a clinically appropriate assessment instrument was not completed. The RN confirmed that an assessment of the pain was not completed during that skin assessment. Pain was rated on a scale of 1-10 in the notes on two other occasions; however, an assessment of the pain using a clinically appropriate assessment instrument specifically designed for pain was not completed.

The home's policy, "Pain and Symptom - Assessment and Management Protocol VII-G-70.00", revised February 2013, directed staff to conduct and document a pain assessment when: there are behaviours exhibited by the resident that may be an indicator for the onset of pain; when there is a change in condition with pain onset; with diagnosis of a painful disease; when resident reports pain or symptoms of greater than 4/10 or 24 to 48 hours; with history of unexpressed pain; with distress related behaviours or facial grimacing; when report from resident, family, staff/volunteers that pain is present; and directed staff to determine the type of pain utilizing Point Click Care (PCC) pain assessment.

The pain assessment tool on Point Click Care (PCC) had not been completed for almost one year.

The skin/wound assessment progress note, identified the resident was sensitive to touch and rated the pain a 7/10. A pain assessment using a clinically appropriate assessment instrument specifically designed for pain was not completed at that time and interventions related to pain were not revised.

Progress notes from the Nurse Practitioner identified the resident had more pain. A pain assessment using a clinically appropriate assessment instrument specifically designed for pain was not completed at that time.

Weekly pain assessment notes discussed other areas that the resident had pain; however, did not include the area the resident stated was painful.

A clinically appropriate pain assessment was not completed when the resident sustained the injury, when there were voiced complaints of pain by the resident, and documentation reflected an increase in pain. [s. 52. (2)] (107)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2015

Order # / Ordre no : 003

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 51. (2) Every licensee of a long-term care home shall ensure that,

(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;

(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;

(e) continence care products are not used as an alternative to providing assistance to a person to toilet;

(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;

(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

(h) residents are provided with a range of continence care products that,

(i) are based on their individual assessed needs,

(ii) properly fit the residents,

(iii) promote resident comfort, ease of use, dignity and good skin integrity,

(iv) promote continued independence wherever possible, and

(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Order / Ordre :

The licensee shall prepare, submit, and implement a plan that ensures that each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence. The plan shall include, but is not limited to:
1. A review of the home's Continence Care and Bowel Management program policies to ensure they provide adequate direction for staff providing care to residents.
2. Education for direct care staff on the home's Continence Care and Bowel Management program.
3. Any quality management activities the home has implemented for monitoring the effectiveness of the program, including person responsible and frequency of auditing, as applicable.

The plan shall be submitted to Long-Term Care Homes Inspector Michelle Warrener via email to: Michelle.Warrener@ontario.ca, by July 10, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

A) Minimum Data Set (MDS) quarterly assessments were reviewed for resident #011 over a six month period. According to the MDS assessments resident #011 had a decline in bladder continence from being usually continent of bladder to occasionally incontinent of bladder. The resident also had a decline in bowel continence, from being continent of bowel to frequently incontinent of bowel. The registered staff indicated that the resident had a decline in bowel and bladder continence and confirmed that when there was a significant change in continence a "Bladder and Bowel Continence Assessment" was required to be completed. The ADOC confirmed that a new assessment tool was developed after the last Resident Quality Inspection (RQI) in October 2014 and staff were advised to complete the assessment using the "Bladder and Bowel Continence assessment" in Point Click Care (PCC). Prior to that, the home had a paper

copy of the assessment tool. The resident's health records were reviewed and the assessment of bladder and bowel continence could not be found for resident #011 when there was a decline. The ADOC confirmed that the bladder and bowel continence assessment was not completed for the resident when there was a significant change in continence. (561)

B) The licensee has failed to ensure that resident #008, who had a change in their level of bowel continence, received an assessment that was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

The resident had a decline in their bowel continence from usually continent of bowels to occasionally incontinent of bowels identified at the quarterly review (identified in the RAI-MDS coding and interdisciplinary care conference summary).

Registered staff stated that they were required to complete a continence assessment on PCC if there was a change in the resident's level of continence. The ADOC and registered staff confirmed a continence assessment using a clinically appropriate assessment instrument was not completed when there was a change in the resident's level of continence. (107)

C) The licensee has failed to ensure that resident #016 received an assessment using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence when the resident had a change in their level of bowel incontinence.

Resident #016 had an assessment related to continence when the resident was admitted to the home. The assessment stated the resident was continent of bowels at that time (seven day observation period was consistent with the resident being continent of bowels). According to PSW flow sheets and PSW/registered staffing interview, the resident became frequently incontinent of bowels.

Flow sheets over a month and a half reflected the resident had 27 incidents of bowel incontinence. Interview with the PSW who routinely provided care for the resident identified that the resident was incontinent almost daily and the current interventions were not effective to manage the resident's incidents of incontinence.

An assessment of the resident's continence was not completed using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence when the resident's continence level changed and the current interventions were unsuccessful. Staff confirmed that a continence assessment using a clinically appropriate assessment instrument was not completed since the admission continence assessment. (107) [s. 51. (2) (a)] (107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 26th day of June, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : MICHELLE WARRENER

Service Area Office /
Bureau régional de services : Hamilton Service Area Office